LUPUS ERYTHEMATOSUS*

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IT IS not my purpose to deliver an exhaustive paper on Lupus Erythematosus this evening, but simply to present to you a brief epitome of the present aspect of the disease, its therapeutics, a description of the Hollaender method, how it was arrived at, and my results with the same.

The disease was called Lupus Erythematosus by Cazenave in 1851, Seborrhoea Congestiva by Hebra in 1845, and Ulerythema Centrifugum by Unna.

The disease begins with one or more pinhead to linnet-seed sized red slightly elevated macules with primarily a smooth glistening surface which later becomes depressed in the center and which depression is either topped by a scale or shows a cicatricial shining dimple. The scale is usually adherent to the patulous duct of a sebaceous gland. Kaposi divides the disease into two forms: lupus erythematosus discoides and lupus erythematosus disseminatus, both of which arise from the above described primary efflorescence. The seat of predilection is the nose and its surrounding structures; the mucous membranes of the face, and the scalp and hands are sometimes attacked, no part of the body being immune. Women are more prone to the disease than men.

Therapeutics—From the number of drugs and procedures that have been recommended it will easily be seen how intractable the disease sometimes is. 1, Kaposi recommends the application of tr. sapo. virid; 2, a 10% salicylic ac. soap plaster has given more or less results; 3, Ichthyol in varying strengths has been used; 4, Resorcine paste 5 to 20%; 5, Ung. hg. ammon. 5 to 10%; 6, Ung. B-naphthohol 3% to 4 %; 7, Lassar's schaelpaste, i. e. sulph. naphthohol paste; 8, Jarish recommends 5 to 10% ac. pyrogall paste; 9, Hot compresses of liq. alum. acet. have been quite successful during the acute stage; 10, linear and punctate scarification as well as radical curettement have been tried; 11, Electrolytic puncture or puntate cauterization with paquelin is advised by Lassar. Hollaender hot air cauterization has been successful with some of Lang's patients; 12, Ung. hg. iod. from 5% to 30%; 13, Cauterization with bichloride hg., collodion ac. carbolic, ac. trichlor acet., sol. Fowler or tr. iod.; 14, Painting with equal parts of spts. vin. rect., spts. menth. pip. and sluph. ether. This was recommended by H. Hebra and used quiet successfully by Neisser, Jarisch and Lang; 15, X-ray and Finsen ray have in some cases given good, and in others no results. I refer to the reports of Freund who has charge of light therapy in the Vienna clinic. My own experience with the Finsen treatment, though favorable, is as yet too limited to allow the drawing of definite conclusions; 16, Internal remedies have never evidenced any specific action, with possibly the exception of quinine 15 to 20 gr. per day given for a number of months as advised by Wolff. Neisser has had some favorable results with this treatment.

Histo-pathology. Many examinations are extant, but I will only cite those of Neumann, Kaposi, Jadassohn and Unna, whose results agree in the main; i. e. inflammatory infiltration of the vessels of the corium, particularly in the subpapilary ones that are distributed to the glands, ducts and hair follicles. This focal infiltration is considered the principal factor, the question at issue being whether the process spreads from below upward or *vice versa.* Jadassohn has shown the process to be diffuse on the surface becoming more circumscribed as it dips deeper into the corium.

Jadassohn's paper of 1896 which discusses the pros and cons of the various publications in favor of and against tubercular origin and connection of the disease, may here be briefly cited, together with the later publications of Roth and C. Boeck.

In favor of its tubercular origin and connection. 1, Lupus Erythematosus is always, or at least most frequently, found in tubercular individuals; 2, Lupus erythematosus patients are often attacked by tuberculosis, especially of the glandular type, and often die of tuberculosis; 3, The clinical picture of lupus erythematosus and lupus vulgaris are very similar; 4, there are transition stages between the two diseases; 5, Lupus erythematosus may react to tuberculin; 6, Roth's statistics prove the presence of tuberculosis in most cases of lupus erythematosus; 7, C. Boeck's hypothesis that the skin lesion is due to toxins evolved by the bacillus tuberculosis in the organism.

Against tubercular origin of lupus erythematosus. 1, Tuberculosis is not more frequent in patients with lupus erythematosus than in those suffering from other chronic diseases; 2, Tuberculosis attacking such patients is either simply accidental or due to the depressing or weakening tendency of the system from long existence and invasion of the disease; 3, Lupus vulgaris and lupus erythematosus are not to be mistaken for one another; 4, The supposed transition stages do not exist and have never been satisfactorily demonstrated; 5, In the majority of cases no tuberculin reaction took place; 6, Histologically they are totally different, neither microscopically, culturally nor by inocculation have tubercle bacilli been demonstrated in lupus erythematosus.

Hollaender, the originator of the hot-air treatment for lupus which up to date is the most satisfactory when large areas are involved, had, among the many lupus cases that came to him for treatment, quite a number of lupus erythematosus patients, none of whom were benefited by

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the treatment. He deduced from this the absence of the bacillus tuberculosis in the skin. Having tried k. i., ergotin and other drugs, thinking the disease due to a capillary disturbance, he stumbled, as it were, upon his present treatment, the internal administration of quinine gr. 7, three times a day, and painting the skin lesion with tr. iod., 10 minutes after the ingestion of the quinine, i. e., upon the reaction of the skin lesions. This reaction he considers pathognomonic and of as much importance in lupus erythematosus as the tuberculin reaction in lupus vulgaris. This treatment is persisted in for about six days when a fair-sized lamellar scab forms which is approximately exfoliated in six days when treatment is again resumed. This course is persisted in for weeks or months until cure takes place. Patients who seem cured but still have an itching sensation in the old patches, though the skin shows no sign of trouble, will quickly react to quinine at these points, demonstrating remaining foci. Quinine without tr. iod. has in some few cases been beneficial, while the sole employment of tr. iod. does rather more harm than good. Having had several cases in the past which gave more than ordinary trouble, no relief being obtained from the many therapeutic procedures, and reading the description of this treatment with the number of reported cases appended, the great simplicity of the treatment and the marvelous results reported, prevailed upon me to try it in a very obstinate case recently under my supervision. We must not lose track of the fact that this disease sometimes tends to sudden auto repair so that a cure, or even several, must not be considered absolute results. What impressed me particularly was the local reaction obtained after the ingestion of quinine.

Date, Jan. 4, 1901. Diagnosis. Lupus Erythematosus. Name, Mrs. L. K. Occupation, housewife. Nativity, Pole. Age, 29. Family history. Father living and healthy; mother died in childbirth; 2 sisters living and healthy; one brother died at sea; another brother, age 24, is healthy. No tuberculosis in family. Previous history: Always healthy; had 2 children at term; has been losing in weight for last year; 5 feet 6 inch in height; weighs 145 lbs.; formerly weighed 160 lbs. Present illness: A patch on the bridge and both sides of the nose and the cheeks adjoining. Butterfly shaped, periphery raised, center depressed, ducts patulous. Physical examination negative, blood negative, hemoglobin 90%; no differential count made; no reaction to the tuberculin test. Treatment: Iodid amylum, drachm i three times a day, emplast hg., locally applied Jan. 11, '01. No result; condition about the same. Feb. '01, creosoti gtts. three times a day; painted with Fowler's solution. Patches slowly enlarging. March, '01. Stopped internal treatment; hot liq. alum. acet. compresses, followed by slight improvement. May, '01. A change to worse; general condition not so good; complains of dizziness, weakness in limbs, skin lesion increasing; a new one on scalp; strychina, gr. 1/40 three times a day and ung. ac. pyrogall. 5%. June, '01, no result; patient discouraged; cessation of treatment; sent to high Sierra. August, '01, improvement in general condition; new patches to left of sternum and on left ear; painted with ac. carb., three times a week. October, '01, no result; patient despondent; pil. asiaticae in increasing doses; painted patches with equal parts of alcohol, ether and spts. peppermint. Nov. '01, slight improvement; no increase of old and no new patches. Jan. '02, general condition poor; insomnia; lack of appetite; physical examination negative; patches on index and middle fingers of right hand resembling chillblains. Stopped arsenic; used punctate paquelin cautery. March '02, condition about the same; elix. ferri quin. et strych., internally, and ichthyol externally. April, '02, slight general improvement. May '02, no improvement; patient hopeless; wishes to try Christian science. Aug. 16, '02, sent for patient; condition worse than when last seen; weight 136 lbs., plaques covering nose, both cheeks, left ear, two patches on scalp, hair destroyed, one near sternum and on index finger of right hand; middle finger seems well. Quinine gr. 8, 3 times a day, and tr. iod., painted on patches on reaction. Aug. 25, '02, good-sized scaly scabs; intermission Sept. 1, '02; scabs exfoliated, patches improved, treatment resumed. Sept. 6, '02, scabs formed, no bad results, treatment discontinued. Sept. 15, '02. Scabs exfoliated, general improvement, patches smaller, treatment resumed. Sept. 20, '02, scabs formed, feeling well, no objection to quinine, treatment discontinued. Sept. 29, '02, scabs exfoliated, marked improvement, patches smaller, finger well, treatment resumed. Oct. 4, '02, scabs formed, feels well, treatment discontinued. Oct. 13, '02, scabs exfoliated, almost cured, treatment resumed. Oct. 18, '02, scabs formed, treatment stopped. Oct. 27, '02, scabs dropped, looks absolutely well, Lassar's paste. Nov. 12, '02, slight itching in site of old patches, particularly on both sides of nose; a little reddening, looks like relapse, treatment resumed. Nov. 18, '02, scabs formed, treatment stopped. Nov. 29, '02, scabs fallen; seems well, treatment resumed. Dec. 4, '02, scabs formed, treatment discontinued. Dec. 11, '02, scabs dropped, patient well, ung. diachili. Jan. 20, '03, no relapse. Feb. 14, '03, no relapse. April 2, '03, no relapse. May 2, '03, no relapse. Aug. 27, '03, patient looks well, has gained greatly in weight, general health good, scars of skin lesions flat and slightly telangiectatic.

The case of the man aged 34 years with a plaque involving left ear and greater part of left cheek has, like the above reported case, gone on to uneventful recovery under this treatment.

Deaths.

Dr. O. H. Simons died at Magnetic Springs, Santa Cruz County, on August 22. He was born in Ohio in 1846, graduated from the University of Pennsylvania, served in the Civil War and was U. S. consul at Hong Kong from 1889 to 1894.

Dr. Warren H. Blood died September 12 at his residence in Oakland of pneumonia. He graduated from Cooper Medical College at the age of 21 and was 39 at time of his death.

A prospective "new remedy"—"Under proper conditions sugar is a remedy against chlorosis, anemia, and in scrofula." *(Drogistsche Rundschau,* translated for *Nat. Druggist.)* It certainly is astonishing that we have not already on the market a number of brands of this new and highly beneficial remedy, each under a controlled name and each infinitely better than any similar preparation that anybody ever heard of. But there is yet time.